TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Hunt Regional Medical Center

Respondent Name
XL Specialty Insurance Co

MFDR Tracking Number
M4-17-3001-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 13, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Furthermore, Gallagher Bassett mishandled the claim processing for service dates 8/10/16-8/31/16… Hunt Regional Medical Center would appreciate all service dates to be reviewed and to determine why Hunt Regional was not provided the proper documentation by Gallagher Bassett."

Amount in Dispute: $9,013.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the documentation received, Coventry stands on the review of this bill. Coventry is standing by the denials and the allowance of the disputed charges: This service was not pre-authorized in conformance with TWCC Rule 134.600."

Response Submitted by: Gallagher Bassett, 4120 International Parkway, Suite 100, Carrollton, TX 75007

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 10 – 31, 2016	Outpatient Hospital Services	$9,013.94	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the requirements for pre-authorization.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 00438 – (197) Precertification/authorization/notification absent
   - 197 – (197) Precertification/authorization/notification absent
   - Z652 – Recommendation of payment is based on a procedure that best describes the series rendered

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking reimbursement in the amount of $9,013.94 for outpatient hospital services performed between August 10, 2016 and August 31, 2016. The insurance carrier denied disputed services with claim adjustment reason code 197 – "Precertification/authorization/notification absent."

   28 Texas Administrative Code §134.600 (p) (2) states in pertinent part,

   (p) Non-emergency health care requiring preauthorization includes:

   (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

   Review of the submitted documentation found no indication the requestor received prior authorization for the services rendered. Therefore the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		July 7, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.